How To Fill Out the Medi-Cal Choice Form

Use the **MEDI-CAL CHOICE FORM(S)**. You can use each form for up to three family members. You can get more forms by calling Health Care Options at 1-800-430-4263.

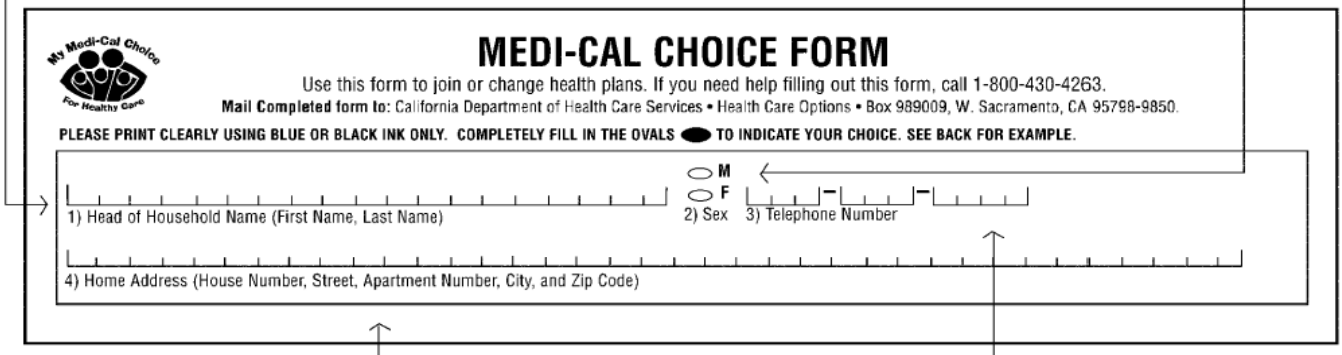
Please print clearly, using blue or black ink only. Write in block letters, and completely fill in all areas to indicate your choice. **See the backside of the choice form for an example.**

Head of Household Name

This section is to be completed by the Medi-Cal head of household.

1. HEAD OF HOUSEHOLD NAME
Print your full name
(First and Last Name).

2. SEX
Fill in oval M for male
or F for female.



4. HOME ADDRESS
Print your home address including the House Number, Street, Apartment Number, City and Zip Code.

3. TELEPHONE NUMBER
Write your home area code and telephone number.

Choosing a Health Plan

Before going on with the form, choose a health plan for each family member. You can choose different plans for each family member. You can also choose different doctors in the same health plan for each family member. After you have made your health plan choice, you can complete the Medi-Cal Choice Form.

Join or Change a Health Plan

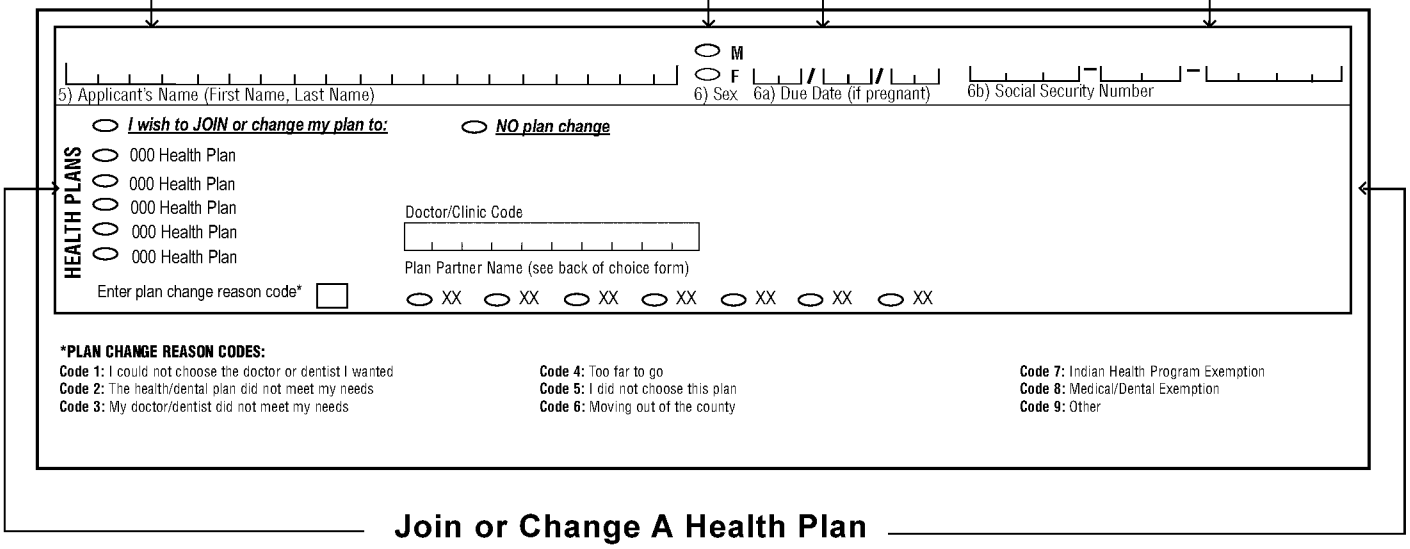
Please complete sections for all members who must join or want to change a health plan.
Parts of this section may already be filled out for you.

5. APPLICANT'S NAME
Print the full name (First and Last Name) of an individual member of your family.

6. SEX
Fill in oval M for male or F for female.

6a. DUE DATE
The due date is the day the baby is expected to be born. Please write the due date by month, day, and year. For example, December 2, 2003 would be entered as 12/02/03.

6b. SOCIAL SECURITY NUMBER
Do nothing if there is a barcode in this space. Otherwise, enter your Social Security Number.



Join or Change A Health Plan

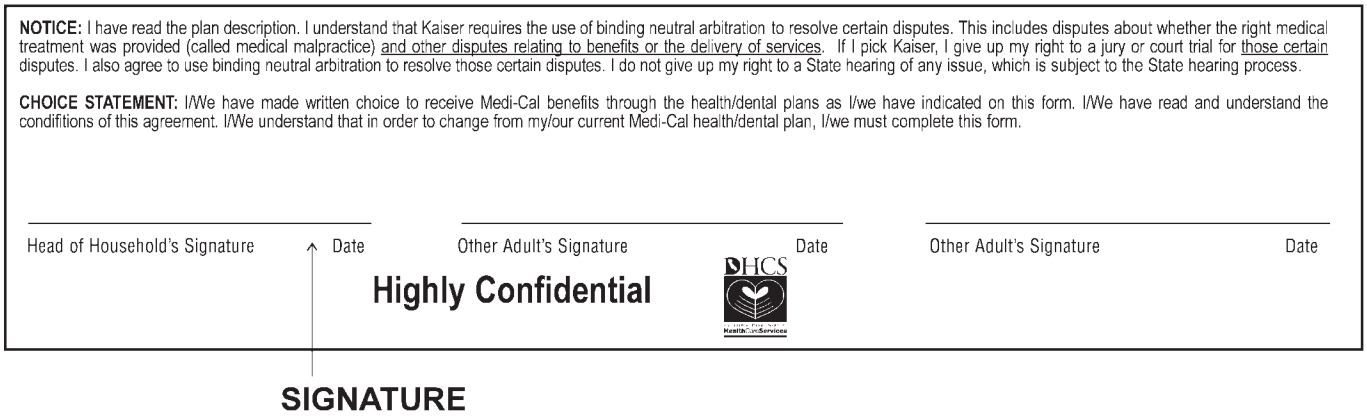
- **Join a Health Plan:**
  Fill in the oval next to "I wish to JOIN or change my plan to:". Then, fill in the oval for your health plan choice.

- **Change a Health Plan:**
  Choose a reason for leaving the health plan from the shaded box called "*PLAN CHANGE REASON CODES" located at the bottom of the form. Write this code number in the box next to "Enter plan change reason code*".

- **If the "*No Plan Change*" oval is available:**
  Fill in the oval for "*No Plan Change*" if any member of the family listed on the choice form does not want to change health plans.

- **Doctor/Clinic and Dentist/Clinic Code:**
  Write the code number for the doctor/clinic and dentist/clinic. This information can be found in the Plan Provider Directory. If there is no number, leave this blank.
  For example, the code number may be listed in the Provider Directory as:
  - ***Dentist's Provider #*** - ***PCP #*** - ***Identification Number (ID)***
  - ***Doctor I.D. Number*** - ***PIN (Provider Identification Number)***
  - ***Provider 0000*** *(ex. provider 3322)*
  - ***# 0000, * 00000 or 00000*** *(ex. # 3322 above or next to the Dentist's name)*

Completing and Mailing the Form



NOTICE: I have read the plan description. I understand that Kaiser requires the use of binding neutral arbitration to resolve certain disputes. This includes disputes about whether the right medical treatment was provided (called medical malpractice) and other disputes relating to benefits or the delivery of services. If I pick Kaiser, I give up my right to a jury or court trial for those certain disputes. I also agree to use binding neutral arbitration to resolve those certain disputes. I do not give up my right to a State hearing of any issue, which is subject to the State hearing process.

CHOICE STATEMENT: I/We have made written choice to receive Medi-Cal benefits through the health/dental plans as I/we have indicated on this form. I/We have read and understand the condifitions of this agreement. I/We understand that in order to change from my/our current Medi-Cal health/dental plan, I/we must complete this form.

Head of Household's Signature Date Other Adult's Signature Date Other Adult's Signature Date

Highly Confidential

DHCS

SIGNATURE

Make sure that you and any other adults listed on the form SIGN and date the form on the bottom.

If you have questions or need help filling out this form, call Health Care Options at 1-800-430-4263. There are also meetings you can attend to discuss health and dental plan choices.

DO NOT CALL YOUR ELIGIBILITY WORKER IF YOU HAVE QUESTIONS ABOUT YOUR MEDI-CAL CHOICE FORM. Your Eligibility Worker can only help you with questions about Medi-Cal benefits or eligibility.